People Quality Integrity Compassion Community

FOUNDATIONS COUNSELING
COMMUNITY FIRST SOLUTIONS

# Intake Demographics Form

| | |
|---|---|
| **Date** | |
| **Name** | **Preferred Name** _____ |
| **Primary Phone**<br>**Alternate Phone** | Primary _____ ☐ cell ☐ landline ☐ work<br>Alternate _____ ☐ cell ☐ landline ☐ work |
| **Email** | |
| **Physical Address** | |
| **Mailing Address** | ☐ Same as Physical Address |
| **Date of Birth** | |
| **Legal Gender** | ☐ Female ☐ Male \| **Birth Sex:** ☐ Female ☐ Male |
| **Preferred Pronouns** | ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____ |
| **Race** | ☐ Alaska Native ☐ Native America ☐ Asian ☐ Black/African American<br>☐ Pacific Islander ☐ White ☐ Other Single Race ☐ 2 or More Races ☐ Unknown |
| **Ethnicity** | ☐ Cuban ☐ Hispanic (no specific origin) ☐ Mexican ☐ Not Hispanic<br>☐ Other Hispanic ☐ Puerto Rican ☐ Unknown |
| **Marital Status** | ☐ Unmarried (never married) ☐ Married (includes domestic partnership) ☐ Divorced<br>☐ Unmarried ☐ Separated ☐ Widowed ☐ Other _____ |
| **Tobacco Use** | ☐ User ☐ Non User **Type of User** _____ |
| **Smoking Status** | ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked |
| **Preferred Language** | |
| **Military Status** | ☐ Active Duty ☐ Disabled Veteran ☐ Honorably Discharged ☐ Other Discharge |

| | |
|---|---|
| | |
| **SSN** | **If no SSN, explain** _____ |
| **How did you hear about us?** | |
| **Employment Status** | ☐ Full-Time ☐ Part-Time ☐ Disabled ☐ Retired ☐ Student ☐ Not Employed |
| **Occupation/Job Title** | **How many days have you worked in the last month?** _____ |
| **Highest Education Completed** | ☐ High School/GED ☐ Some College ☐ 2-Year College Degree ☐ 4-Year College Degree ☐ Graduate Degree ☐ Technical Certificate ☐ Other _____ |
| **# of Individuals in Household** | |
| **Do you have any dependents?** | ☐ YES ☐ NO **If NO, can someone else claim you as a dependent?** ☐ YES ☐ NO |
| **Source of Income** | |
| **Emergency Contact** | **Name/Relationship** _____ **Phone** _____<br>*If no emergency contact is identified, please understand that no one will be contacted in the event of a medical or behavioral health crisis, outside of the necessary healthcare professionals. |

**Payer Information**

| | |
|---|---|
| **Primary Insurance** | Name: _____ Policy ID: _____ |
| **Subscriber Information** | ☐ Self<br>Name: _____<br>Birthdate: _____ Relationship: _____ |
| **Secondary Insurance** | Name: _____ Policy ID: _____ |
| **Subscriber Information** | ☐ Self<br>Name: _____<br>Birthdate: _____ Relationship: _____ |
| **Self-Pay** | ☐ I do not have insurance and will be paying out-of-pocket. |

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

## Community Behavioral Health and Foundations Counseling Core Intake Packet

| | |
|---|---|
| **Client Name:** | |
| **Date:** | |
| **Client Program:** | |

**INFORMED CONSENT**

**Consent for Services and Consent to Participate in Telehealth Services**

| | |
|---|---|
| **Consent Type:** | ☐ Initial Consent ☐ Withdrawal of Current Consent |

**CONSENT FOR SERVICES**

I consent to assessment and treatment by Community Behavioral Health.

I agree to actively participate in my treatment, as outlined in my individualized treatment plan.

I agree to be contacted by email, mail, phone, and/or text during the course of my treatment.

I understand that follow-up contact may occur for up to 24 months following my discharge from treatment.

**I UNDERSTAND MY RIGHTS AS FOLLOWS**

When required by regulatory or CBH policy, a diagnosis, when given, must be explained along with symptoms associated with the diagnosis.

Agency information and program-specific information and rules will be provided to me.

Both benefits and risks of my treatment must be explained to me.

Goals, Objectives, Interventions will be reviewed, as set forth in my treatment plan, and adjustments made as deemed clinically appropriate. This will be a collaborative process between myself and my provider.

My service provider(s) are skilled and properly credentialed to provide services within the scope of their practice.

My service provider's qualifications must be provided to me.

I have the right to terminate services or withdraw my consent to receive services at any time. Should I choose to refuse or withdraw consent for treatment, the potential impacts of my

actions in doing so must be explained to me. I understand that information regarding my treatment is protected by state and federal law, and I acknowledge that I have been offered a copy of the rules governing confidentiality, and that the rules have been explained to me.

| | |
|---|---|
| **Do you agree to consent for treatment and Services?** | ☐ YES ☐ NO |

**CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES**

Telehealth is the provision of behavioral health service through interactive video conferencing.

I understand that telehealth is a live, two-way interaction between myself and a clinician/employee of Community Behavioral Health using audiovisual telecommunication technology.

I understand that telehealth is voluntary and that I may refuse to participate at any time verbally or in writing. I understand that my participation, refusal to participate, or decision to stop participation will be documented in my electronic health record.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth. I understand that during a pandemic these laws may be waived by government officials in order to continue to provide care.

Prior to receiving services, I will be educated and the process of telehealth will be explained. I understand that I may not record the audio content or the images of the session.

I have read this document and have had the opportunity to ask questions. I hereby consent to participation in treatment via telehealth video conferencing.

| | |
|---|---|
| **Do you agree to consent for treatment and Services?** | ☐ YES ☐ NO |

**PHOTOGRAPHY CONSENT**

☐ I **DO NOT** consent to all images taken and videos filmed of me and / or my dependent child(ren). (Disregard 1-5 below)

☐ I **DO** consent to all images taken and videos filmed of me and / or my dependent child(ren). (Complete 1-5 below)

**I AGREE THAT IMAGES MAY BE:**

| | |
|---|---|
| 1. Used by healthcare professionals for client identification | ☐ YES ☐ NO |
| 2. Used by healthcare professionals for education and training. | ☐ YES ☐ NO |
| 3. Used in paper or electronic healthcare publications. | ☐ YES ☐ NO |
| 4. Used in commercial broadcasts. | ☐ YES ☐ NO |
| 5. Used in marketing materials. | ☐ YES ☐ NO |

## ACKNOWLEDGEMENT

I further acknowledge that images and videos are not limited to one date and there are no promises of compensation between client and Community Behavioral Health and/or Community First Solutions, for the use of photos and videos, as outlined in this consent.

This consent may be changed/revoked at any time with written request by the patient.

## 42 CFR PART 2 PROGRAMS

### WRITTEN SUMMARY OF FEDERAL CONFIDENTIALITY LAW & REGULATIONS FOR CUSTOMERS IN ALCOHOL AND/OR DRUG PROGRAMS

In accordance with 42 C.F.R. Part 2 alcohol and other drug customer records are subject to the following confidentiality conditions: Community Behavioral Health complies with these requirements.

1. Program staff shall not convey to a person outside of the program that a customer receives services from the program or disclose any information identifying a customer as an alcohol or drug services customer unless the customer consents in writing for this release of information, the disclosure is allowed by court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purpose.

2. Violation of the federal law and regulations governing this Program is a crime. Suspected violations may be reported to the United States Attorney's Office, Southern District of Ohio, 221 E. Fourth Street, Suite 400, Cincinnati, OH 45202, (513) 684-3711.

3. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a customer either at the program or against any person who works for the program.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Federal authorities.

Effective 3/31/10, Revised 9/22/21

## ACKNOWLEDGEMENT OF CLIENT HANDBOOK

### THE CLIENT HANDBOOK CONTAINS THE FOLLOWING INFORMATION

* Location, Hours of Operation, Services Offered
* Attendance Policy
* Notice of Privacy Practices
* 42 CFR Part 2 Programs
* Standards of Ethical Practice and Professional Conduct
* Client Rights
* Client Grievance Procedures & Resource Agencies

* Advanced Directives
* Crisis Line Information
* Emergency Site and Safety Information
* Infectious Disease Prevention
* Preventing Opioid Overdose

**BY SIGNING THIS DOCUMENT**
I acknowledge that I have been offered a copy of the Community Behavioral Health Client Handbook.

I agree to read and become familiar with the information contained in the handbook.

I agree to seek clarification from my provider or CBH support staff to fully understand the content of the handbook, if necessary.

I agree to comply with all policies, laws, and regulations as stated within the Community of Behavioral Health Client Handbook.

## PATIENT RESPONSIBILITY

Thank you for choosing Community Behavioral Health for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and complete this form to acknowledge your understanding of your current patient financial responsibilities.

1) The patient (or patient's parent/legal guardian, if a minor) is ultimately responsible for the payment for treatment and care.

2) We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.

3) Clients with commercial insurance payers - coverage of services by commercial payers may vary depending on our organization's specific provider agreement with each commercial payer.

4) You will be responsible for any fees associated with services that are not covered by your specific commercial insurance company or insurance plan.

5) Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

6) Copays are due at the time of service.

7) Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

8) Patients may incur, and are responsible for, payment of additional charges, if applicable. These charges may include a charge for returned checks up to $30.00

**PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION**

We respect patient confidentiality and only release personal health information about you in accordance with the state and federal law. Our privacy notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature on this document, I acknowledge that I have received and read the privacy notice provided by Community Behavioral Health and I hereby authorize Community Behavioral Health and the physicians, staff, and hospitals associated with Community Behavioral Health to release medical and other information acquired during the course of assessment and treatment to the necessary insurance companies, third party payers, other physicians or healthcare entities required to participate in my care.

Furthermore, I hereby authorize assignment of financial benefits directly to Community Behavioral Health and any associated healthcare entities for services rendered as allowable under standard third party contracts, and I understand that I am financially responsible for charges not covered by this assignment.

Community Behavioral Health reserves the right to change or modify the terms and conditions of this agreement if we feel it becomes necessary.

## SIGNATURES

| | |
|---|---|
| Print Name & Relationship to Client Served: | |
| Signature: | |
| Date: | |

| | |
|---|---|
| Print Name & Relationship to Client Served: | |
| Signature: | |
| Date: | |

| | |
|---|---|
| Staff Name: | |
| Signature: | |
| Date: | |

People Quality Integrity Compassion Community

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

## MINOR BILLING INFORMATION FORM

CLIENT NAME:_____ LEGAL GENDER: F M IDENTIFIED GENDER _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY #: _____ BIRTHDATE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: (___) _____

EMERGENCY CONTACT: _____ PHONE: (___) _____

---

CUSTODIAL PARENT NAME: _____ PRIMARY PHONE: (____) _____

EMAIL ADDRESS: _____ May we identify Foundations? Y N

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE'S NAME: _____ PRIMARY PHONE: (____) _____

---

NON-CUSTODIAL PARENT: _____ PRIMARY PHONE: (____) _____

May we identify Foundations? Y N

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

---

WHO REFERRED YOU?_____

INSURED PARTY:_____ BIRTHDATE:_____

EMPLOYER:_____ SOC. SEC. #:_____

INSURANCE CO:_____

CLAIMS ADDRESS:_____

INS. CO. PHONE: (___) _____ POLICY:_____

I understand and agree that **regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered,** and that payment is due at the time those services are rendered. I further understand that the initial one to three sessions are for the purpose of evaluation (i.e., to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Foundations client. **I have read all the information on both sides of this sheet and agree to the conditions set forth. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.**

*I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Foundations, the counselors, and other Foundations staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill, and for issues that concern Foundations operations and responsibilities.*

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

# Health History Questionnaire

**This form should be completed as fully as possible by client but reviewed by medical staff**

| **Client Name:** | **Client #:** | **Age:** | **Date:** |
|---|---|---|---|

**Review of Health Problems**: Has the client had any of the following health problems?

| | **Now** | **Past** | **Never** | **Document Treatment Received and Date(s)** |
|---|---|---|---|---|
| Anemia | | | | |
| Arthritis | | | | |
| Asthma | | | | |
| Bleeding Disorder | | | | |
| Blood Pressure (high or low) | | | | |
| Bone/Joint Problems | | | | |
| Cancer | | | | |
| Cirrhosis/Liver Disease | | | | |
| Diabetes | | | | |
| Epilepsy/Seizure Disorder | | | | |
| Eye Disease/Blindness | | | | |
| Fibromyalgia/Muscle Pain | | | | |
| Glaucoma | | | | |
| Headaches | | | | |
| Head Injury/Brain Tumor | | | | |
| Hearing Problems/Deafness | | | | |
| Heart Disease | | | | |
| Hepatitis/Jaundice | | | | |
| Kidney Disease | | | | |
| Lung Disease | | | | |
| Menstrual Pain | | | | |
| Oral/Health/Dental Problems | | | | |
| Stomach/Bowel Problems | | | | |
| Stroke | | | | |
| Thyroid | | | | |
| Tuberculosis | | | | |
| AIDS/HIV | | | | |
| Sexually Transmitted Disease | | | | |
| Learning Problems | | | | |
| Speech Problems | | | | |
| Anxiety | | | | |
| Bipolar Depression | | | | |
| Depression | | | | |
| Eating Disorder | | | | |
| Hyperactivity/ADD | | | | |
| Schizophrenia | | | | |
| Sexual Problems | | | | |
| Sleep Disorder | | | | |
| Suicide Attempts/Thoughts | | | | |
| Other: | | | | |
| Other: | | | | |

**Please note family history of the above conditions and client's relationship to that family member:**

## Additional Health Information

| | | | |
|---|---|---|---|
| Has client had medical hospitalizations and/or surgical procedures in the last 3 years? | ☐ Yes | ☐ No | |
| If YES, please list HOSPITAL, CITY, DATE, REASON for hospitalizations and/or surgical procedures: | | | |

**Allergies/Drug Sensitivities**

| | |
|---|---|
| ☐ | No Known Allergies |
| ☐ | Food (specify): |
| ☐ | Medication (specify): |
| ☐ | Other (specify): |

**Pregnancy History - FEMALES ONLY**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ **N/A (If N/A, you may skip this section)** | | | | | | | |
| Currently Pregnant? | ☐ Yes | ☐ No | If yes, expected delivery date: | | | | |
| Are you receiving Prenatal Healthcare? | | ☐ Yes | ☐ No | Do you take prenatal vitamins? | ☐ Yes | ☐ No | |
| If yes, who is your provider? | | | | | | | |
| Currently Breastfeeding? | ☐ Yes | ☐ No | When was your last menstrual cycle? | | | | |
| Any Significant Pregnancy History? | ☐ Yes | ☐ No | | | | | |
| If yes, explain: | | | | | | | |

**DO NOT LEAVE THIS SECTION BLANK**

**Who is your PRIMARY CARE PROVIDER?** (name and estimated date last seen)

| **Has client had any of the following symptoms in the past 60 days? (check all that apply)** | | | | |
|---|---|---|---|---|
| ☐ Ankle Swelling | ☐ Coughing | ☐ Lightheadedness | ☐ Penile Discharge | ☐ Urination Difficulties |
| ☐ Bed-Wetting | ☐ Cramps | ☐ Memory Problems | ☐ Vaginal Discharge | ☐ Pulse Irregularities |
| ☐ Vision Changes | ☐ Blood in Stool | ☐ Diarrhea | ☐ Mole/Wart Changes | ☐ Seizures |
| ☐ Breathing Difficulties | ☐ Dizziness | ☐ Muscle Weakness | ☐ Shakiness | ☐ Vomiting |
| ☐ Chest Pain | ☐ Falling | ☐ Nervousness | ☐ Sleep Problems | ☐ Other: |
| ☐ Confusion | ☐ Gait Unsteadiness | ☐ Nosebleeds | ☐ Sweats (night) | ☐ Other: |
| ☐ Consciousness Loss | ☐ Hair Changes | ☐ Numbness | ☐ Tingling in Arms/Legs | ☐ Other: |
| ☐ Constipation | ☐ Hearing Loss | ☐ Panic Attacks | ☐ Tremors | ☐ Other: |

**Immunization - Vaccines (check all that apply)**

| | | | | |
|---|---|---|---|---|
| ☐ **N/A** | ☐ COVID-19 | ☐ Dengue | ☐ Chickenpox (Varicella) | ☐ Pneumococcal |
| ☐ Diphtheria* | ☐ Flu (Influenza) | ☐ Hepatitis A | ☐ Hepatitis B | ☐ Rubella (German Measles)** |
| ☐ Measles** | ☐ Mumps** | ☐ Rotovirus | ☐ HPV (Human Papillomavirus) | |
| ☐ Tetanus (Lock Jaw)* | ☐ Pertussis (Whooping Cough)* | ☐ Shingles (Herpes Roster) | ☐ Hib (Haemophilus influenzae type b) | |
| ☐ Meningoccocal | | | ☐ Polio (Poliomyelitis) | ☐ Other: |
| **Vaccines received within the past year (if applicable):** | | | | |

***Given in combination as DtaP** ****Given in combination as MMR** **Source: Centers for Disease Control and Prevention**

## Additional Health Information

**Height/Weight**

| | | | |
|---|---|---|---|
| Height: | | | |
| If reporting for a child, has height changed in the past year? | ☐ Yes | ☐ No | |
| If yes, by how much (+ or -)? | | | |
| Weight: | | | |
| Has client's weight changed in the past year? | ☐ Yes | ☐ No | |
| By how much (+ or -)? | | | |
| Have you gained or lost more than 10 pounds in the last 3 months? | ☐ Yes | ☐ No | |

**Nutritional Screening**

| | | | | | |
|---|---|---|---|---|---|
| Drinking | □ No Change | □ Less | □ More | □ Takes Liquids Only | |
| Eating | □ No Change | □ Less | □ More | □ Not Eating | |
| Appetite | □ No Change | □ Decreased | □ Increased | | |
| Are you satisfied with your eating patterns? | | | | ☐ Yes | ☐ No |
| Do you ever eat in secret? | | | ☐ Yes | ☐ No | |
| Do you make yourself sick because you feel uncomfortably full? | | | | ☐ Yes | ☐ No |
| Do you worry you have lost control over how much you eat? | | | | ☐ Yes | ☐ No |
| Does your weight affect how you feel? | | | | ☐ Yes | ☐ No |
| Do you currently suffer with or have you suffered from an eating disorder in the past? | | | | | ☐ Yes ☐ No |
| Have any members of your family suffered from an eating disorder? | | | | ☐ Yes | ☐ No |
| Additional Comments : | | | | | |

**Dental History**

| | | | |
|---|---|---|---|
| Approximate Date of Last Dental Exam (month/year): | | | |
| Name of Dentist: | | | |
| Are you having dental problems now? | ☐ Yes | ☐ No | |
| Are you apprehensive about dental treatment? | | ☐ Yes | ☐ No |
| Are your teeth sensitive to hot, cold, sweets, pressure? | | ☐ Yes | ☐ No |
| Do you brush your teeth daily? | ☐ Yes | ☐ No | |
| Do you wear dentures? ☐ Yes | ☐ No | | |
| Have you ever had periodontal (gum) treatment? | | ☐ Yes | ☐ No |
| Do your gums bleed, or feel tender or irritated? | | ☐ Yes | ☐ No |
| Do you have headaches, earaches, or neck pain? | | ☐ Yes | ☐ No |
| Do you regularly use dental floss? | ☐ Yes | ☐ No | |
| Additional Comments: | | | |

**Pain Screening**

| | | | |
|---|---|---|---|
| Are you experiencing paing today? | | ☐ Yes | ☐ No |
| If yes, on a level of 1-10, how would you rate your pain? | | | |
| Does pain currently interfere with your activities? | | ☐ Yes | ☐ No |
| If yes, how much does it interfere with these activities? □ Mildly □ Moderately □ Extremely □ Severely | | | |
| Please indicate the source of your pain: | | | |

## Substance Use History

**Substance Use History and Current Use**

| | | | | |
|---|---|---|---|---|
| Alcohol/Beer/Wine | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Marijuana | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Hashish | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Stimulants | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Sleep Medication | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Tranquilizers | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Hallucinogens | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Inhalants | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Cocaine/Crack | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Opioids (i.e. Heroin) | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Pain Medication | ☐ No Use | ☐ Past Use | ☐ Current Use | |
| Other: | | | | |
| Caffeine use? | ☐ Yes | ☐ No | | |
| What form(s) of caffeine do you use? | | | | |
| How much do you consume each week (i.e. cups, bottles, etc.)? | | | | |
| Tobacco use? | ☐ Yes | ☐ No | | |
| What form(s) of tobacco do you use? | | | | |
| How much do you use each week (i.e. packs, etc.)? | | | | |

# OFFICE USE ONLY

**Comments, Recommendations, or Referrals by Medical Reviewer**

☐ No Referral Needed ☐ Primary Care Physician ☐ Healthcare Agency ☐ Specialty Care

Specify Action(s)

| | | | |
|---|---|---|---|
| **Were the Provider's recommendations shared with client?** | ☐ Yes | ☐ No | |

If yes, document client's repsonse:

If no, how will the recommendations be shared with the client?

People Quality Integrity Compassion Community

COMMUNITY FIRST SOLUTIONS

# Client Handbook

***Thank you for choosing Foundations Counseling. Our VISION is a community where supportive services ensure active, productive, social and healthy individuals. We look forward to serving you!***

**Accreditation and Certification**

**Foundations Counseling is certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and is accredited by The Joint Commission.**

1900 Fairgrove Avenue | Hamilton, OH 45011 | (513) 785-4895 |
1501 Alexandria Pike | Suite 104 | Ft. Thomas, KY 41075 | (859) 442-1218 |
www.Foundations-Counseling.org

## Table of Contents

People Quality Integrity Compassion Community

# COMMUNITY BEHAVIORAL HEALTH

COMMUNITY FIRST SOLUTIONS

**820 S. Martin Luther King Jr. Boulevard, Hamilton, OH 45011**
**Phone: (513) 887-8500**
**Fax: (513) 737-8196**
**Hours: Monday – Thursday 8:00 AM to 7:00 PM**
**Fridays 8:00 AM to 4:00 PM**

We believe in people, and we believe in outcomes

Our success with clients stems from the variety of individualized treatment plans we offer, and from the team approach we take with managing caseloads. As a subsidiary of Community First Solutions, we have the backing of an organization dedicated to making an impact on the lives of all people in our community.

Nobody falls through the cracks

Whatever it takes to get from point A to point B, we have the tools to help people be successful. Regardless of their agency preference or insurance limitations, we facilitate connections to ensure no one falls through the cracks.

Team Approach to Managing Care

Our team designs individualized treatment plans to meet each client's unique needs. One of our dedicated staff members remains a point person for the client, while the rest of the team provides additional expertise and resources needed for successful outcomes.
We ensure all clients have people in their corner, painting them a picture of a brighter future, helping them set and achieve goals, and walking alongside them each step of the way.

***Our outpatient clinic located on Martin Luther King Jr offers comprehensive services for Mental Health and Substance Use Disorders, including individual and group counseling/therapy, case management, and psychiatric medical services for adults and children.***

People Quality Integrity Compassion Community

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

**1900 Fairgrove Avenue (Rt. 4), Hamilton, OH 45011**
**Phone: (513) 785-4895**
**Fax: (513) 785-4896**
**Hours: Monday to Thursday 9:00 AM to 8:00 PM**
**Friday 9:00 AM to 6:00 PM**
**Saturday Bi-Weekly 9:00 AM to 2:00 PM**

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**1501 Alexandria Pike, Ft. Thomas, KY 41075**
**Phone: (859) 442-1218**
**Hours: Monday to Thursday 8:00 AM – 7:00 PM**
**Friday 8:00 AM to 12:00 PM**

It is our mission at Foundations to be there when you need us, to offer an ear to listen, and to be a support to help you through tough times, we help you develop a strong foundation to successfully manage whatever challenges you may be facing.

Whether you are struggling with family or marriage relationships, wrestling with financial strains, facing a difficult work situation, recovering from addictions, or dealing with a past or recent trauma, you will be greeted empathy, kindness, and authenticity.

Find strength for today and hope for tomorrow with Foundations counseling.

***Our outpatient clinic located on Fairgrove Ave. offers comprehensive services for Mental Health Disorders, including individual counseling/therapy for adults and children, family therapy, and couples counseling.***

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

## STATEMENT OF UNDERSTANDING

**WELCOME**

Welcome to Foundations Counseling. This introductory letter has been prepared to acquaint you with our services. We provide confidential assessment, counseling and treatment services. We look forward to working with you to be sure you receive prompt, effective treatment and regain your health and ability to function safely and productively.

**OUR SERVICES**

Our goal is to focus on your health and well-being as well as work related issues. Services are provided by licensed therapists with Master's Degrees in counseling, psychology and social work. Our services include assessment, counseling, coordination of treatment, and follow-up. We follow a model of counseling tailored to your specific needs. Each session lasts approximately 50 minutes. If you need other help it may be necessary to make a referral to another professional. When this occurs, it is important that you be aware of the extent of your medical health coverage. All services are provided by Foundations Counseling, and not affiliated with LifeSpan.

**CONFIDENTIALITY**

Your counseling records are confidential and secured. Information will not be released to anyone without your written consent except in the following situations:

1) Indication of a clear and present danger of harm to you or other persons.
    - Child abuse or neglect situation; or
    - Abuse or neglect of a dependent adult that is in your care; or
    - Admission of a commission of a crime or a serious health condition that poses a risk to a patient and/or public safety.
2) A court order or other legal order (e.g. a subpoena), or as otherwise required or permitted by law.
3) If you file a complaint or lawsuit against your counselor, your counselor may disclose relevant information about you in order to defend her/himself.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

In some situations, you will be asked to sign a release of information consent form. The Release of Information form allows Foundations Counseling to release only specific information to the individual(s) you specify. This is necessary to coordinate your care and ensure you appropriate assessment and/or treatment.

*All clients treated for a mental health or substance use disorder, when services are covered in whole or in part by Medicaid – Medicaid HMO, ADAMH Board, or OhioMHAS*: Ohio Mental Health and Addiction Services has implemented a data tracking system for all providers in the state of Ohio known as OBHIS (Ohio Behavioral Health Information System). As a mental and behavioral health provider, we are mandated to disclose demographic, billing and other general information pertaining to current active clients. By signing this document you are agreeing to release information to the State of Ohio.

**SERVICES NOT COVERED**

It is the policy of Foundations Counseling not to participate in client's legal actions such as custody evaluations/cases, divorce proceedings, personal injury lawsuits, etc. If you are considering or are involved in such actions, your Foundations counselor can refer you to another professional who may be able to assist you in these matters.

**QUALITY OF SERVICE**

We would like to ensure that you have the highest quality of services possible. If you experience any concerns or have questions about our services, please feel free to contact Foundations Counseling at (513) 785-4895.

# Foundations Fee Schedule and Cancellation Policy

## ABOUT FINANCIAL ARRANGEMENTS AND MENTAL HEALTH SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

## FEE SCHEDULE

Most insurance policies cover some percentage of outpatient counseling. You should find out the following information **prior** to your first visit to our office:

1. **What is my deductible? Have I met my deductible yet?**
   You are responsible to pay the full fee of services until your deductible is met.
2. **Do I need pre-authorization for outpatient treatment?**
   Many insurance plans operate under a "pre-authorized" concept. If your counselor at Foundations is not "pre-authorized" to provide treatment, you may be denied payment by your insurance company.
   **PLEASE NOTE: We strongly encourage you to contact your insurance company BEFORE your first session. Foundations will not be responsible for denial of claims if you have not notified your insurance company for pre-authorization; or, if we are not a covered provider under your plan.**
3. **What percentage of the fee will my insurance pay and what percentage am I responsible to pay?**
   Upon arrival at Foundations, clients are expected to pay **at least** their portion of the fee at each and every session. You should anticipate paying the full fee for the diagnostic session.
4. **Who receives the reimbursement check?**
   If the insurance company sends the check directly to us: (1) you will receive a credit if you "pay-as-you-go," or (2) the payment will be added to your weekly co-payment.

   If the insurance company sends the check directly to you: expect to pay the full fee for each session.

You are ultimately responsible to pay any balance that your insurance company may not cover. We realize that you may have special arrangements with a non-custodial parent for payment of medical bills; however, we do not bill third parties. You are responsible for the bill at the time services are rendered.

## CANCELLATION POLICY

Because the demand for counseling is so great, we take very seriously our responsibility to be good stewards of our time and resources. **If you are unable to keep your appointment, please contact us 24 hours prior to your scheduled appointment. Failure to contact us within the 24-hour window to cancel your appointment, may result in the client being charged the FULL AMOUNT due for the session. Also, NO SHOW, or same day appointment cancellations may be charged the full amount due. We maintain a 24-hour answering service at 513-785-4895 in case an appointment must be broken.**

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

**NOTICE OF PRIVACY PRACTICES**

Effective 3/31/10, Revised 06/26/2020

*THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*
*PLEASE REVIEW IT CAREFULLY.*

**Therapists and Case Managers at this agency are not on-call and are not responsible for responding to emails, phone calls or text messages outside of their normal working hours. Client understands if they have an emergency after hours they can reach out to 911 or contact the National Suicide and Crisis Lifeline by calling or texting 988.**

Community Behavioral Health ("CBH") is required by law to maintain the privacy of your health information. CBH is required to provide this notice of its legal duties and privacy practices with respect to your private health information. The health information which CBH protects is information about you that relates to your health, condition, health care provided to you, and payment for health care services. CBH calls that information Protected Health Information, or "PHI." CBH is dedicated to maintaining the privacy of your health information.

**WHO WILL FOLLOW THIS NOTICE**

This notice applies to CBH. When used in this notice the term "We" or "CBH" refers to CBH. We are required to follow the terms of this notice so long as it remains in effect.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

CBH may use and disclose your PHI as described in this notice. The following categories provide examples of ways that we may use and disclose your PHI. These examples do not provide every use and disclosure permitted.

**Treatment**. We may use and disclose your PHI for your treatment. For example, we may disclose information about you to doctors, nurses, counselors, healthcare professionals in training and other personnel involved in your treatment or services. Different departments of CBH may share your PHI to coordinate your care. We may share your PHI with others involved in your care or treatment, such as your family physician, pharmacy, or home health care agency, who may or may not be associated with CBH.

**Payment.** We may use and disclose your PHI as necessary for payment for your treatment or services. For example, we may provide PHI to your insurance company about a treatment or service you received so that the insurer will pay for services. We may also inform your insurance company about a planned treatment or service so that prior approval may be obtained, or to determine if your insurance plan covers the planned treatment or service.

**Health Care Operations.** We may use and disclose your PHI for CBH operations. For example, we may use your PHI to evaluate the performance of CBH staff in their care of you. Other uses can include matters such as quality improvement activities, business management or accreditation. We may also disclose information to other health care providers involved in your care or treatment for their health care operations.

**Health Services, Treatment Alternatives and Health-Related Benefits**. We may use and disclose your PHI to tell you about health-related benefits or services that we offer, possible treatment options or alternatives, or health related benefits or services that may be of interest to you. We may also use your PHI to communicate with you and coordinate your care.

**Appointments**. We may use and disclose your protected health information to contact you as a reminder that you have an appointment or to reschedule a missed appointment for treatment or services.

**Fundraising**. We may contact you to donate to a fundraising effort for us or on our behalf. You may elect not to receive further fundraising materials/communications by sending a statement to that effect, including your name and address to: Privacy Officer, 230 Ludlow St, Hamilton, Ohio 45011.

**Other Individuals Involved With or Concerned About Your Care**. We may disclose your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), or to a friend or family member who is your personal representative (i.e. empowered under state or other law) to make health-related decisions for you. If you do not object, or if we reasonably infer from the circumstances (for example, if your spouse remains present while discussing treatment options with your doctor) we may also disclose relevant health information to a family member, other relative, or close personal friend, or any other person you identify who is involved with your case or payment for your care.

**Required By Law**. We will use or disclose your PHI when that use or disclosure is required by law. Any such use or disclosure will comply with, and be limited to, the permissions or requirements of the law.

**Serious Threat to Health or Safety.** In certain situations, and as allowed by law, we may use and disclose your PHI when necessary to prevent a serious threat to your health and safety of the public or another person.

**Business Associates.** CBH contracts with outside vendors to provide some services. These vendors are known as business associates. We may disclose your PHI to business associates. For example, we may provide your PHI to an external company that assists us in processing bills. CBH's business associates are required to safeguard your PHI.

**Military and Veterans.** If you are or were a member of the U.S. or foreign armed forces, we may disclose your PHI as required by military command authorities.

**Worker's Compensation**. We may disclose your PHI to worker's compensation insurers, state administrators, employers, and other persons or entities involved in the workers' compensation system, as authorized by law, and as applicable to your treatment and care.

**Public Health.** We may disclose your PHI for public health activities, including activities to: prevent or control disease, injury or disability; report births and deaths; report child or adult abuse, neglect or violence; report reactions to medications or problems with products; notify people of recalls of products they may be using, or notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition.

**Health Oversight Activities.** We may disclose your PHI to federal or state agencies for health oversight activities such as audits, investigations, inspections and licensure. This disclosure would be as necessary

for the government to monitor the health care system, government programs and compliance with laws.

**Lawsuits and Disputes.** We may disclose your PHI in response to a court or administrative order, or certain subpoenas.

**Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety of and security of the correctional institution.

**OTHER USES OF PROTECTED HEALTH INFORMATION**

Other uses and disclosures of your protected health information not covered by this notice or the laws and regulations that apply to CBH will be made only with your written permission. If you authorize CBH to use or disclose protected health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons listed in your written authorization. The revocation will not apply to uses or disclosures that have already occurred. Also, we will continue to comply with laws that require certain disclosures.

**YOUR PRIVACY RIGHTS**

**Review or Copy.** You have the right to request to review and/or receive a copy of your PHI. All requests for access to your PHI must be in writing and signed by you. We may charge you a fee, especially if extensive and/or non-recent personal health information is requested. We may also charge for postage if you request a mailed copy. In some limited situations, your request to review or receive a copy may be denied. In some denial situations, you have the right to have the denial evaluated by a reviewing official. Based upon the determination of the reviewing official we will then provide or deny access. To request to review and/or receive a copy of your protected health information, you will need to complete a signed release of information authorization form that may be obtained from your local Foundations Counseling office.

**Amendment.** You have the right to request that your protected health information be amended if you think that your protected health information in our records is incorrect or incomplete. All requests for amendments must be made in writing and signed by you. All amendment requests must also state the reason(s) for the amendment/correction request and the specific amendment/correction requested. We are not obligated to make all requested amendments but will give each request careful consideration. For example, an amendment request may be denied if the information to be amended was not created by us or is not part of our protected health information kept by our facility. If an amendment you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment form you're your local Foundations Counseling office.

**Accounting of Disclosures.** You have the right to request an "accounting" or list of certain disclosures CBH has made of your PHI. This "accounting" or list is not required to include all disclosures. For example, we are not required to account for routine disclosures between CBH staff coordinating your treatment or care. Types of disclosures not required in the "accounting" or list are: disclosures for treatment, payment, or health care operations, disclosures made before April 14, 2003; disclosures made more than six years prior to the date on which the "accounting" or list is requested; disclosures made to you or which you authorized; and certain other disclosures, such as disclosures for national

security or intelligence purposes. To request this accounting of disclosures and obtain information about possible fees, contact: Privacy Officer, Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011.

**Restrictions on Disclosures.** You have the right to request a restriction or limit on your protected health information we use or disclose about you for treatment, payment or health care operations. If your requested restriction relates to our disclosure of your PHI to a health plan and pertains solely to a health care item or service for which you have paid, out-of-pocket, in full, we will comply with your request. Otherwise, we are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. Restriction requests should usually be in writing and you must state: (1) what information you want to limit; (2) whether you want to limit CBH's use, disclosure or both; and (3) to whom you want the limits to apply. We may terminate an agreement to a restriction if we inform you of this termination. We will notify you of such termination, if applicable. You may also request to terminate a restriction or limitation. To request a restriction or limit on your protected health information, contact: Community Behavioral Health, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

**Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we call you at your office, rather than at your home. We will not require you to explain the reason for your request. We will accommodate reasonable requests. Confidential communication requests should usually be in writing and you must specify how or where you wish to be contacted. To request an alternative communication means or location, contact: Foundations Counseling, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

**Paper Copy of This Notice**. You have the right to receive a paper copy of this notice even if you have agreed to receive this notice electronically. You may obtain a paper copy from your Primary Counselor. This notice is also available on Community Behavioral Health's website www.Foundations-Counseling.org.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as for any information we receive in the future. We will post a copy of the current notice in the agency and on Community Behavioral Health's website www.Foundations-Counseling.org**.**

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a written complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with the Privacy Officer, contact: Privacy Officer Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011. Generally, a compliant must be filed with HHS within 180 days after the act or omission occurred, or within 180 days of when you knew or should have known of the action or omission. You will not be retaliated against or denied treatment or discriminated against for filing a complaint.

**FURTHER INFORMATION**

If you have questions or need further assistance regarding this notice, you may contact: Privacy Officer, Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011.

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

**WRITTEN SUMMARY OF FEDERAL CONFIDENTIALITY LAW & REGULATIONS FOR CUSTOMERS IN ALCOHOL AND/OR DRUG PROGRAMS**

In accordance with 42 C.F.R. Part 2 alcohol and other drug customer records are subject to the following confidentiality conditions: This agency complies with these requirements.

- Program staff shall not convey to a person outside of the program that a customer receives services from the program or disclose any information identifying a customer as an alcohol or drug services customer unless the customer consents in writing for this release of information, the disclosure is allowed by court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purpose.
- Violation of the federal law and regulations governing this Program is a crime. Suspected violations may be reported to the United States Attorney's Office, Southern District of Ohio, 221 E. Fourth Street, Suite 400, Cincinnati, OH 45202, (513) 684-3711.
- Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a customer either at the program or against any person who works for the program.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Federal authorities.

# Ohio Administrative Code

## Rule 4757-5-01 Standards of ethical practice and professional conduct.

Effective: October 18, 2009

(A) The code of ethical practice and professional conduct constitutes the standards by which the professional conduct of counselors, social workers, and marriage and family therapists shall be measured. Each subject area is in a separate rule within Chapter 4757-5 of the Administrative Code.

(B) The rules of standards of ethical practice and conduct shall apply to the conduct of all counselor, social worker, and marriage and family therapist licensees and registrants.

(C) A violation of these rules of standards of ethical practice and professional conduct constitutes unprofessional conduct and is sufficient reason for a reprimand, suspension, revocation, other disciplinary action, or for restrictions placed upon a license or for the denial of the initial license or renewal, or reinstatement of a license.

(D) The board subscribes to codes of ethics and practice standards for counselors, social workers, and marriage and family therapists promulgated by the "American Counseling Association" and the "National Association of Social Workers" and the "American Association for Marriage and Family Therapy". These association standards shall be used as aids in resolving ambiguities which may arise in the interpretation of the rules of professional ethics and conduct, except that the board's rules of standards of ethical practice and professional conduct shall prevail whenever any conflict exists between these rules and the professional association standards.

# Client Rights

We are pleased that you have chosen COMMUNITY BEHAVIORAL HEALTH as your mental health and alcohol/drug addiction services provider. We look forward to working with you. Before treatment begins, we would like you to know and understand what your rights are as our client.

Subject to applicable State and Federal Law, Community Behavioral Health complies with client rights in accordance with **Ohio Administrative Code Sections 5122-26-18 and 5122:2-1-02**. Client rights and grievance information are posted in our lobbies, included in the client handbook, and copies may also be requested directly from our support staff.

## YOUR RIGHTS AS OUR CLIENT

1) The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;

2) The right to service in a humane setting, which is the least restrictive feasible as defined in the treatment plan;

3) The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;

4) The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client;

5) The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;

6) The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;

7) The right to freedom from unnecessary or excessive medication;

8) The right to freedom from unnecessary restraint or seclusion;

9) The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific reason which precludes and/or requires that client's participation in other services;

10) The right to be informed of and refuse any unusual or hazardous treatment procedures;

11) The right to be advised of and refuse any observation by techniques such as one-way vision mirrors, tape recorders, television, movies or photographs;

12) The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;

13) The right to confidentiality of communications and of all personally identifying information with the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal

statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Ohio Administrative Code;

14) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client, the factual information about the individual client that necessitates the person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;

15) The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event;

16) The right to receive an explanation of the reasons for denial of services;

17) The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;

18) The right to know cost of services;

19) The right to be fully informed of all rights;

20) The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;

21) The right to file grievance; and

22) The right to have oral and written instructions for filing a grievance.

## CLIENT RIGHTS PROCEDURES

1) Staff are available to explain any and all aspects of client rights and/or grievance procedures upon request;

2) Client rights policies are given to each client at intake via written and verbal methods;

3) In a crisis or an emergency situation, the client will be verbally advised of the immediately pertinent rights, such as right to consent to or refuse the offered treatment, as well as the consequences of that agreement of refusal;

4) Client rights information and/or Community Behavioral Health Client rights and Grievance Policy is posted in all public areas of Community Behavioral Health;

5) All staff is familiar with all client rights and the grievance procedure via staff orientation and re-orientation on an annual basis.

## Grievance Procedures

1) Any current or former client of Community Behavioral Health may file a grievance with the Clients Rights Officer (C.R.O.) of Community Behavioral Health. The grievance will include: date, time, description of incident or situation, and the names of the individuals involved. The C.R.O. must assist the griever in filing a grievance upon request. The griever may use Community Behavioral Health grievance form. The signed and dated grievance will be submitted in writing to the C.R.O.

**Agency Client Rights Officer**
**820 S. Martin Luther King Jr. Blvd.**
**Hamilton, Ohio 45011**
**(513) 868-4980**

2) Following submission of a grievance, the C.R.O. must respond to the griever in writing or verbally acknowledge receipt of the grievance and arrange a hearing with the C.R.O. This response must be within five (5) working days. Either the C.R.O. or the griever may include other parties to insure an impartial, unbiased hearing by the designated impartial decision maker. There shall be a reasonable opportunity for the griever and/or his/her designated representative to be heard by the C.R.O.

The C.R.O. is responsible for assisting the griever in investigation of the grievance and shall try to resolve the grievance during this initial phase. The C.R.O. shall assure the keeping of records of grievances received, the subject matter of grievance, and the resolutions of the grievances. Community Behavioral Health records are available for review by the Butler County Mental Health Board and Alcohol and Drug Addiction Services Board. If the C.R.O. is the subject of a grievance, Community Behavioral Health, CEO will appoint an alternate C.R.O. who is impartial.

3) If the grievance cannot be resolved to the griever's satisfaction through the C.R.O., he/she may request a hearing with Community Behavioral Health's President or CEO.

4) At any point during the grievance, the griever may contact the Ohio Legal Rights Service, 50 W. Broad Street Columbus, Ohio 43215 (614-466-7264) or 1-800-282-9181.

The griever may also initiate a complaint with the U.S. Department of Health and Human Services or appropriate local/state/federal licensing or regulatory associations. At the Agency level, it is expected that any grievance resolution will not exceed twenty (20) working days from the date the grievance was filed.

5) Written notification and explanation of the resolution will be provided to the client or to the griever, if other than the client.

6) The C.R.O. will provide, upon request, all relevant information about the grievance to one or more organizations to which the griever has initiated a complaint.

7) Community Behavioral Health's President and CEO, assures that all staff and Board members understand their responsibility to immediately advise any client or any griever about the name and availability of the C.R.O. and the complainant's right to file.

8) The C.R.O. has full authority to take whatever steps are necessary to assure agency compliance with the Client Rights Policy and the Grievance Procedure, and the C.R.O. will keep written records of all grievances filed, for at least two years, and responses generated. These will be reviewed by the Community Behavioral Health President and CEO, The Board of Trustees, and the Quality Improvement Committee as necessary but at least annually.

9) The agency C.R.O. submits an annual summary to the Mental Health Board and quarterly summaries to the Alcohol Drug Addiction Services Board that includes the number of grievances, the types of grievances, and the resolution status of each grievance.

**CLIENT RIGHTS AND GRIEVANCE RESOURCE AGENCIES**

In most cases, problems are best solved by the parties most directly involved. The most important resource in a grievance about mental health and alcohol/drug addiction services is usually your Agency and its own grievance procedure. You also have the right to bring your grievance to any of the resources listed below. They may or may not be appropriate for your specific situation.

Ohio Legal Rights Services
50 W. Broad St, Suite 1400
Columbus, OH 43215-5923
1-800-282-9181
(614) 466-7264
(614) 644-1888 (fax)

Office of the Americans with Disabilities Act
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, DC 20530
1-800-514-1301
1-800-514-0383 ADA info line
www.usdog.gov/crt/ada/adahom1

Equal Employment Opportunity Commission (U.S.)
131 M Street, Northeast
Washington, DC 20507
1-800-669-4000
(202) 663-4900

State Medical Board
30 E. Broad Street, 3rd Floor
Columbus, OH 43215-6127
(614) 466-3934, (614) 728-5946 (fax)
www.state.oh.us/med

Ohio Department of Alcohol and Drug Addiction Services
Professionals Board
77 S. High St., 16th Floor
Columbus, OH 43215
(614) 387-1110

Ohio Department of Mental Health and Addiction Services
30 E. Broad Street, 8th Floor
Columbus, OH 43215-3430
(614) 466-2596

Butler County ADAS Board
Six South Second Street, Suite 420
Hamilton, OH 45011
(513) 867-0777

Attorney General's Office (Ohio)
Health Care Fraud Unit
State Office Towers
30 E. Broad Street, 14th Floor
Columbus, OH 43215-3428
(614) 466-4986

Equal Employment Opportunity (Cleveland Office)
Anthony Celebreeze Federal Bldg
1240 E. 9th St., Suite 3001
Cleveland, OH 44199
1-866-408-8075
(216) 522-2001 or (216) 522-2002

Nursing Education & Nurse Registration Board
17 S. High St., Suite 400
Columbus, OH 43215-7410
(614) 466-3947
www.state.oh.us/nur

Ohio Department of Health
Division of Quality of Assurance
Complaint Section
246 N. High Street, 3rd Floor
Columbus, OH 43215
1-800-342-0553

Ohio Governor's Council on People with Disabilities
150 E. Campus View Blvd
Columbus, OH 43235
1-800-282-4536 Ext. 391
(614) 438-1394
www.state.oh.us./gcpd

President's Committee on Employment of People with Disabilities
1331 F. Street, NW, Suite 300
Washington DC, 20004
(202) 376-6200, (202) 376-6205 (TTY)
www.pcepd.gov

Office for Civil Rights
U.S. Department of Health and Human Services
Attn: Regional Manager
233 N. Michigan Ave., Suite 240
Chicago, Ill. 60601

Ohio Legal Rights Services
50 W. Broad St., Suite 1400
Columbus, OH 43215-5923
(614) 466-7264
(614) 644-1888 (fax)

U.S. Department of Health and Human Services
Attn: Cristal Thomas
Office for Civil Rights - Region V
233 N. Michigan Ave. Ste 1300
Chicago, IL
(312) 353-5160

Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, OH 43215
(614) 466-2100
www.state.oh.us/odjfs

Ohio Psychiatric Association
1350 W. 5th Ave., Ste 218
Columbus, OH 43202-2907
(614) 481-7555, (614) 481-7559 (fax)

Butler County Mental Health and Recovery Services Board
5963 Boymel Drive
Fairfield, OH 45014
(513) 860-9240

State Board of Psychology
77 S. High Street, Suite 1830
Columbus, OH 43215-6108
(614) 466-8808
www.state.oh/us/phy/

U.S. Department of Social Security
Office of Public Inquiries
6401 Security Blvd
Baltimore, MD 21235-6401
1-800-772-1213
1-800-325-0778

Office of Quality & Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
630-792-5800

# Advance Directives for Mental Health Treatment in Ohio

Advance directives are documents which state your instructions today about your health care for the future, in case you become unable to speak for yourself at the time you need treatment. You can state your instructions about the kinds of treatment you want and do not want, who may provide you treatment and who may not, and where you will and will not receive treatment.

In Ohio, "advance directives" is the term used to describe three types of legal documents you can complete to express your wishes regarding your future health care: (1) a **Durable Power of Attorney** for health care (POA), (2) a **Declaration for Mental Health Treatment**, and (3) a **Living Will**. An advance directive can be an important tool for you as a consumer of mental health and other disability services to guide your care should your attending physician determine that you lack capacity to make your own health care choices.

The **Durable Power of Attorney** for health care can state your instructions about medical treatment or mental health treatment or both. The **Declaration for Mental Health Treatment** can state your instructions for mental health treatment. You may have both of these documents stating your instructions about mental health treatment, but the declaration for mental health treatment controls.

The most important difference between these two documents is that the durable power of attorney for health care is always "revocable:" you may change or cancel your instructions at any time. The declaration for mental health treatment is not always "revocable:" if you become unable to make your own decisions because of a mental illness, you will be bound by the instructions for treatment that you gave when you created the document.

## CONTACT INFORMATION

Contact the Disability Rights Ohio for more information regarding Advance Directives for Mental Health Treatment in Ohio

Call 614-466-7264 or 1-800-282-9181 Monday to Friday 9 AM to 12 PM and 1 PM to 4 PM

Disability Rights Ohio
Attn: Intake
200 Civic Center Dr.
Columbus, Ohio 43215

Disability Rights Ohio is designated under federal law as the system to protect and advocate the rights of people with disabilities and as the Client Assistance Program under the Rehabilitation Act. The mission of Disability Rights Ohio is to advocate for the human, civil, and legal rights of people with disabilities in Ohio.

**IMPORTANT: If you have an emergency and need immediate assistance, CALL 911**
**This is a 24-hour crisis emergency line.**

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# Emergency and Site Safety Information

**Emergency Exit Information**

Emergency exit maps have been posted throughout the building and the following information is marked on evacuation maps:

- Nearest emergency exits
- Primary and secondary evacuation routes, if applicable
- Locations of fire extinguishers
- Locations of fire alarm pull stations
- Locations of tornado safety zones

**Animals/Pets**

Animals and/or pets are not permitted in any Community Behavioral Health facilities, except for service animals. **The Americans with Disabilities Act (ADA) defines service animals as dogs that are individually trained to do work or perform tasks for individuals with disabilities.** Per ADA guidelines**,** a service animal must be under the control of its handler. Under the ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

**Smoking Policy**

Use of tobacco products is prohibited in any Community Behavioral Health facilities.

**Illicit Drugs Policy**

Use of illicit drugs is prohibited in any Community Behavioral Health facilities.

**Weapons Policy**

Community Behavioral Health prohibits the possession, transport, and storage of any weapons on facility properties in order to secure a safe environment for employees, clients, and clients. Individuals who are licensed to carry a weapon still have to refrain from bringing weapons on facility properties. This policy does not apply to any law enforcement personnel engaging in official duties.

"Facility properties" covered in this policy includes all facilities owned or leased. This also pertains to the surrounding areas, such as sidewalks, walkways, parking lots and driveways.

"Weapons" include, but are not limited to, handguns, firearms, explosives, knives and other items that may be defined as weapons under state, federal or local laws or ordinances.

It is illegal to carry a firearm, deadly weapon, or dangerous ordnance anywhere on these premises unless authorized to do so by law. No person shall knowingly possess, have under the person's control, convey or attempt to convey a deadly weapon to dangerous ordnance onto these premises. Posted pursuant to the Ohio Revised Code.

# Infectious Disease and Prevention

## Coronavirus Disease (COVID-19)

### Overview

Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.

Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. However, some will become seriously ill and require medical attention. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness. Anyone can get sick with COVID-19 and become seriously ill or die at any age.

The best way to prevent and slow down transmission is to be well informed about the disease and how the virus spreads. Protect yourself and others from infection by staying at least 1 meter apart from others, wearing a properly fitted mask, and washing your hands or using an alcohol-based rub frequently. Get vaccinated when it's your turn and follow local guidance.

The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols. It is important to practice respiratory etiquette, for example by coughing into a flexed elbow, and to stay home and self-isolate until you recover if you feel unwell.

### Prevention

To prevent infection and to slow transmission of COVID-19, do the following:

- Get vaccinated when a vaccine is available to you.
- Stay at least 1 meter apart from others, even if they don't appear to be sick.
- Wear a properly fitted mask when physical distancing is not possible or when in poorly ventilated settings.
- Choose open, well-ventilated spaces over closed ones. Open a window if indoors.
- Wash your hands regularly with soap and water or clean them with alcohol-based hand rub.
- Cover your mouth and nose when coughing or sneezing.
- If you feel unwell, stay home and self-isolate until you recover.

### Symptoms

COVID-19 affects different people in different ways. Most infected people will develop mild to moderate illness and recover without hospitalization.

#### Most common symptoms:

- fever
- cough
- tiredness
- loss of taste or smell

**Less common symptoms:**

- sore throat
- headache
- aches and pains
- diarrhea
- a rash on skin, or discoloration of fingers or toes
- red or irritated eyes

**Serious symptoms:**

- difficulty breathing or shortness of breath
- loss of speech or mobility, or confusion
- chest pain

Seek immediate medical attention if you have serious symptoms. Always call before visiting your doctor or health facility.

People with mild symptoms who are otherwise healthy should manage their symptoms at home.

On average it takes 5–6 days from when someone is infected with the virus for symptoms to show, however it can take up to 14 days.

**Source: World Health Organization**

## Hepatitis B

Hepatitis B is a vaccine-preventable liver infection caused by the hepatitis B virus (HBV). Hepatitis B is spread when blood, semen, or other body fluids from a person infected with the virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby at birth.

Not all people newly infected with HBV have symptoms, but for those that do, symptoms can include fatigue, poor appetite, stomach pain, nausea, and jaundice. For many people, hepatitis B is a short-term illness. For others, it can become a long-term, chronic infection that can lead to serious, even life-threatening health issues like cirrhosis or liver cancer.

Risk for chronic infection is related to age at infection: about 90% of infants with hepatitis B go on to develop chronic infection, whereas only 2%–6% of people who get hepatitis B as adults become chronically infected. The best way to prevent hepatitis B is to get vaccinated.

**Source: Centers for Disease Control**

## Hepatitis C

Hepatitis C is a liver infection caused by the hepatitis C virus (HCV). Hepatitis C is spread through contact with blood from an infected person. Today, most people become infected with the hepatitis C virus by sharing needles or other equipment used to prepare and inject drugs.
For some people, hepatitis C is a short-term illness, but for more than half of people who become infected with the hepatitis C virus, it becomes a long-term, chronic infection. Chronic hepatitis C can result in serious, even life-threatening health problems like cirrhosis and liver cancer. People with chronic hepatitis C can often have no symptoms and don't feel sick. When symptoms appear, they often are a sign of advanced liver disease ( i.e fatigue, jaundice, dark urine, joint pain, sore muscles).

There is no vaccine for hepatitis C. The best way to prevent hepatitis C is by avoiding behaviors that can spread the disease, especially injecting drugs. Getting tested for hepatitis C is important, because treatments can cure most people with hepatitis C in 8 to 12 weeks.

**Source: Centers for Disease Control**

## HIV/AIDS

HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure. Once people get HIV, they have it for life. With proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners.

Some people have flu-like symptoms within 2 to 4 weeks after infection (called *acute HIV infection*). These symptoms may last for a few days or several weeks. Possible symptoms include

- Fever,
- Chills,
- Rash,
- Night sweats,
- Muscle aches,
- Sore throat,
- Fatigue,
- Swollen lymph nodes, and
- Mouth ulcers.

Some people may not feel sick during acute HIV infection. These symptoms don't mean you have HIV. Other illnesses can cause these same symptoms.

**Source: Centers for Disease Control**

(Page 1 is in English, Page 2 is in Spanish)

June 2021

# HIV 101

**Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.**

## HIV CAN BE TRANSMITTED BY

Sexual Contact

Sharing Needles to Inject Drugs

Mother to Baby During Pregnancy, Birth, or Breastfeeding

## HIV IS NOT TRANSMITTED BY

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

## PROTECT YOURSELF FROM HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.

- If you are at risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

## KEEP YOURSELF HEALTHY AND PROTECT OTHERS IF YOU HAVE HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.

- Tell your sex or injection partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

For more information, please visit **www.cdc.gov/hiv.**

## Tuberculosis

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

**Symptoms** of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as

- a bad cough that lasts 3 weeks or longer
- pain in the chest
- coughing up blood or sputum (phlegm from deep inside the lungs)

Other symptoms of TB disease are

- weakness or fatigue
- weight loss
- no appetite
- chills
- fever
- sweating at night

Symptoms of TB disease in other parts of the body depend on the area affected.
People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB to others.

**Preventing Latent TB Infection from Progressing to TB Disease**
Many people who have latent TB infection never develop TB disease. But some people who have latent TB infection are more likely to develop TB disease than others. Those at high risk for developing TB disease include:

- People with HIV infection
- People who became infected with TB bacteria in the last 2 years
- Babies and young children
- People who inject illegal drugs
- People who are sick with other diseases that weaken the immune system
- Elderly people
- People who were not treated correctly for TB in the past

If you have latent TB infection and you are in one of these high-risk groups, you should take medicine to keep from developing TB disease. There are several treatment options for latent TB infection. You and your health care provider must decide which treatment is best for you. If you take your medicine as instructed, it can keep you from developing TB disease. Because there are less bacteria, treatment for latent TB infection is much easier than treatment for TB disease. A person with TB disease has a large amount of TB bacteria in the body. Several drugs are needed to treat TB disease.

**Source: Centers for Disease Control**

## Sexually Transmitted Infections

Sexually transmitted diseases (STDs), also known as sexually transmitted infections (STIs), are very common. Millions of new infections occur every year in the United States.

STDs pass from one person to another through vaginal, oral, and anal sex. They also can spread through intimate physical contact like heavy petting, though this is not very common.

STDs don't always cause symptoms or may only cause mild symptoms. Therefore, it is possible to have an infection and not know it. That is why getting an STD test is important if you are having sex. If you receive a positive STD diagnosis, know that all are treatable with medicine and some are curable entirely.

**Common STD's are**: Bacterial Vaginosis, Chlamydia, Human Papillomavirus (HPV), Trichomoniasis, Gonorrhea, Hepatitis, Herpes, HIV/AIDS, Pelvic Inflammatory Disease (PID), and Syphilis.

**Vaccines** are safe, effective, and recommended ways to prevent hepatitis B and HPV. HPV vaccination is recommended for preteens ages 11 or 12 (or can start at age 9) and everyone through age 26, if not vaccinated already.

**Take Control**

Reducing your number of sex partners can decrease your risk for STDs. It is still important that you and your partner get tested, and that you share your test results with one another.

Correct and consistent use of the male latex condom is highly effective in reducing STD transmission. Use a condom every time you have anal, vaginal, or oral sex.

If you have latex allergies, synthetic non-latex condoms can be used. But it is important to note that these condoms have higher breakage rates than latex condoms. Natural membrane condoms are not recommended for STD prevention.

Mutual monogamy means that you agree to be sexually active with only one person, who has agreed to be sexually active only with you. Being in a long-term mutually monogamous relationship with an uninfected partner is one of the most reliable ways to avoid STDs. But you must both be certain you are not infected with STDs. It is important to have an open and honest conversation with your partner.

**Source: Centers for Disease Control**

PREVENTING AN OPIOID OVERDOSE

# Know the Signs. *Save a Life.*

## Opioid Overdose Basics

Prescription opioids (like hydrocodone, oxycodone, and morphine) and illicit opioids (like heroin and illegally made fentanyl) are powerful drugs that have a risk of a potentially fatal overdose. Anyone who uses opioids can experience an overdose, but certain factors may increase risk including but not limited to:

- Combining opioids with alcohol or certain other drugs
- Taking high daily dosages of prescription opioids
- Taking more opioids than prescribed
- Taking illicit or illegal opioids, like heroin or illicitly-manufactured fentanyl, that could could possibly contain unknown or harmful substances
- Certain medical conditions, such as sleep apnea, or reduced kidney or liver function
- Age greater than 65 years old

Death from an opioid overdose happens when too much of the drug overwhelms the brain and interrupts the body's natural drive to breathe.

Learn more about opioids to protect yourself and your loved ones from opioid abuse, addiction, and overdose: www.cdc.gov/drugoverdose

CDC

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

# PREVENTING AN OPIOID OVERDOSE

## Signs and Symptoms of an Opioid Overdose

During an overdose, breathing can be dangerously slowed or stopped, causing brain damage or death. It's important to recognize the signs and act fast. Signs include:

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin

## What To Do If You Think Someone Is Overdosing

It may be hard to tell if a person is high or experiencing an overdose. If you aren't sure, it's best to treat it like an overdose– you could save a life.

1. Call 911 immediately.
2. Administer naloxone, if available.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with him or her until emergency workers arrive.

*Ask your doctor about naloxone - a safe medication that can quickly stop an opioid overdose. It can be injected into the muscle or sprayed into the nose to rapidly block the effects of the opioid on the body.*

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